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A Case Illustration Employing "Counter-Conditioning Therapy®" in the Treatment of Substance-Abuse Outpatients

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ABSTRACT.

A clinical case based upon a chronic substance-abuse patient receiving "Counter-Conditioning Therapy®" treatment is described. This unified, non-cognitive out-patient treatment design concentrates the therapy effort on material originating from a patient's non-volitional, emotional mental pattern. Counter-Conditioning Therapy®, a psychotherapy configured to counteract the negative effects of the non-volitional mental pattern, does not abide by the traditional treatment practice of regarding human behavior matters in a "disease" context. This mental health treatment unit has been developed and employed in the field since 1967. Over that period of time, a broad treatment spectrum of mental health problems has received attention at the Center.

Before entering the Center's substance-abuse program, hard-core abusers are required to dry-out elsewhere for 10-14 days. The case-example presented is typical of any one of the two hundred substance abuse cases which have received treatment at the Center since 1980. Critical treatment matters which the traditional medical-model community overlooks are identified. Counter-Conditioning Therapy® substance-abuse treatment procedures which address those discrepancies in medical-model clinical design are advanced.

A CASE ILLUSTRATION EMPLOYING "COUNTER-CONDITIONING THERAPY®" IN THE TREATMENT OF SUBSTANCE-ABUSE CASES

The format described herein is based upon several premises, namely:

1) that mental conditioning is a native feature of human beings, the non-volitional ingredients of that conditioning decide the outcome of everyone's future behavior;

2) that human beings do not willfully create pain for themselves - as all human beings instinctively gravitate towards less mental pain;

3) that depression is a pre-condition in the mental make-up of potential substance-abusers;

4) that the over-consumption of a substance, any substance, is an attempt by the patient to cope, personally, with chronic low-level depression;

5) that ongoing low-level depression, with its mental capacity for increased levels, is a feature of mental conditioning, copied from parental figures in the child's growing-up environment; and,

6) that overconsumption, the tactic employed by the abusing patient to alleviate the pain of depression, is also a "copied" mental mannerism.

Patients are referred for treatment at the "Center for Counter-Conditioning Therapy®" through the usual mental health and alcohol-abuse sources: employee assistance programs, physicians, social service agencies, and by word-of-mouth. Patient motivation is the criterion for suitability to the Counter-Conditioning Theraapy® substance-abuse program.

It is the purpose of this report, to demonstrate through case-study:

A) An innovative mental health methodology and its application in the treatment category of substance-abuse. This representative case demonstrates the Counter-Conditioning Therapy® treatment approach to alcohol-abuse. Without resorting to moral, spiritual or disease-based modalities, the treatment task becomes a matter of providing the patient with the mental means to counter-act those aberrant features that stem from the workings of an inherent -- not to be confused with inherited -- condition. Through the Center, our patients have learned to neutralize negative aspects of the forceful nature of that inherent condition and have satisfactorily achieved a state of self-managed -- "controlled consumption."

B) Three clinical constituents which the Center views as critical to the success of any treatment plan, follow:

(1.) incipient chronic depression provides the mental sustenance for substance-abuse;

(2.) the function of the "ritual" act of abusing carries a tendency to compete against recovery;

(3.) the destruction of and the practise by traditional treatment modalities to replace habit-based ritual activity with an innocuous substitute fuels the production of "anxiety." A program of withdrawal requires careful planning and supervision.

C) One substance-abuse constant is the patient's attempt to replicate his comforting ritual of "crony" association.

D) A patient's spontaneous pursuit of "feeling better" as a prelude to a patient's abusing tendencies.

It is worth emphasizing at this point that any treatment intervention, regardless of its common-sense reasons for the patient to change his abusing habit, mentally sets the patient up to struggle against changing the abusing "status quo." Clinical observation reinforces the Center's early discovery that an increase in the level of "anxiety" is the inevitable result of a change in long-term activity. Active resistance to change signals the patient's confrontation with his ritual and heralds the beginnings of mental improvement.

How do hypothesis and design relate to the problem?

The Center does not assert, nor advance any presumption, that external events, either past or present, promote substance-abuse. Instead, the Center employs a treatment unity founded upon a non-volitional system-design of mental functioning, one aspect being that a patient's early human associations have a long-term mental impact upon his future behavior. In order to supply the patient with a way of coping with this long-term mental pattern and its long-term mental impact, the "Counter-Conditioning Therapy®" format applies an innovative treatment approach, teaching the patient a mental health skill. The C-CTherapy® skill provides the patient with an alternative to being "run" by his mental conditioning. The therapist "instructs" the patient in the clinical project of "building" an alternative mental framework to that acquired in childhood. As the patient begins to feel better, his motivation to build for himself a mental health skill increases.

The clinical procedure involves the patient in mental exercises designed to bring about a change in the patient's mental operation. The therapist closely monitors the patient's practising of the mental exercises and guides the patient through the therapy steps. *Building a mental health skill* allows the patient to mentally counteract the negative features in his mental pattern. In the past, these negative features served as source-material for self-victimization. Counter-Conditioning Therapy® treatment operates from the premise that human beings are not victimized by their environment or their past experiences. Emotions are not decided, they do not result from logic and reason. The patient, therefore, does not direct himself to become upset. Instead, it is a patient's conditioned response to experiences from his past which determines the character of his emotional reactions in the present. This mental pattern, because of its longevity, possesses an emotional strength which fuels the self-victimization activity.

The Center's treatment approach makes use of the innate human predilection to move from "pain to less pain." This approach is contrary to the current supposition that human beings decide their own emotional fate and thus participate in their own mental upset. Consequently, the "Counter-Conditioning Therapy®" treatment program attracts patients who are motivated to seek-out "feeling" better. Introduced to C-CTherapy®, these patients are quick to appreciate the pay-off of their personal efforts. Therefore, the Center's only rule for participation in the program is a patient's willingness to work along skill-building treatment lines. Concentrating upon events in the patient's past is not part of the treatment approach at the Center.

The common denominator in all substance abusing is the need to get "high" and thus neutralize negative thought voices, such as, "nothing to look forward to in life," "everyone is having a better time than me" and "life is passing me by".

Also at the Center, abstinence is not a requisite to entering into treatment, but a diminished abuse level is. The patient hallucinating from the affects of LSD or drunk on "booze" is in no working-state to participate in a "skill-acquisition" project. Therefore, patients who wish only to be taken care of by supportive psychotherapy or spirituality programs screen themselves out of this treatment process. These kinds of patients, if they are not seeking "parenting," tend to cling to the notion that they have to be "cured" of an affliction -- originally created by someone other than themselves -- via the intervention of someone they regard as possessing all life's answers.

Here a distinction must be made between the Counter-Conditioning Therapy® outpatient setting and a medical-model in-hospital or institutionally-directed program. In the Counter-Conditioning Therapy® outpatient setting, there is no moral suasion adjudicating the patient's behavior. The patient has to be fed-up with his substance abusing ritual and come to the Center of his own volition. Our patients seek out treatment, therefore, not because they label themselves abusers, but because they are in a state of emotional distress and keen to do something more redeeming than continue-on in mental "pain." That they routinely poison themselves is a piece of behavioral

information that is not, by itself, viewed as worrisome at the Center. What is more significant is the frequency of the complaining and scapegoating voiced by the patient. Complaining and scapegoating tells us that the non-volitional system is fully active. We have entitled this phenomenon as "thought voices," because it is this very "thinking" activity which acts as a precusor and perpetuator of abusing.

An in-hospital/institutional setting is governed by an attitudinal atmosphere which is either medical (a disease/illness is causing the abusing behavior) or moral (the abusing behavior is "bad"), often both. For instance, patients find themselves committed to a kind of "Bedlham Hospital" facility because they have been "bad." The Center, on the other hand, maintains a clinical stance free from "understanding the patient's past life" or judging his behavior as "sinful." The Center promotes an outpatient atmosphere which leans towards a "normalcy" view of aberrant human behavior. The classification "disease" and the jurisdiction of "morality" are viewed as separate. The Center does not confuse physical medicine precepts with the precepts which underpin a spirituality, morality approach. The Center maintains that aberrant behavior is not a disease. The psuedo-jurisdiction of disease/morality belongs to either a legal setting or the established church.

THE IMPLICATIONS OF THE *NON-DISEASE* STUDY

This empirical study describes three critical treatment areas which any clinical program must address if it is to have an impact upon the patient's inclination to over-consume.

1) The presence of chronic low-level depression and its accompanying anxiety fosters over-consumption.

2) In an effort to overcome that chronic production of depression and anxiety, the patient practises self-treatment -- "self-anaesthesia."

3) The social and ritualistic nature of the patient's over-consuming tendencies points to the human need to be included in a group activity. Human beings are innately gregarious. The compulsion to be a member of something, and thus "belong," takes on *illogical properties* which interfere with a person's need to "quit." This condition of "wanting to belong" applies especially to chronically depressed patients, for chronically depressed patients in particular, *change creates anxiety*. Any treatment approach which fails to address this reaction to change sets the patient up for relapse.

This study confirms an earlier clinical suspicion by the authors: "Whenever a patient's mental routines are disturbed, *anxiety* sets in." Ironically, this result occurs despite the patient's emotional relief. Beginning to "feel good" is an emotional "stranger" to the patient's reactive pattern, even though logic and reason preaches to the contrary.

When this scenario of a "composite depression" (acute depressive-reaction derived from systemic poisoning, combined with low-level chronic depression) becomes a routine, any clinical disruption from the patient's emotional habit pattern will automatically trigger contrariness. This discovery is monumental. The authors maintain that insufficiencies in current clinical designs, because they are not customized to deal with the existence of anxiety-creation, hobbles the patient's inclination to resolve his abusing habits. Therefore, any successful treatment modality must be designed, specifically, to derail the development of this illogical mental factor.

HOW STUDY RELATES TO PREVIOUS WORK IN THE FIELD

Currently, there are "Spirituality, 12-Step" programs and various disease-model medical programs, in combination

and in variation (e.g. Sanchez-Craig, 1990, client "choices" model). However, none of these treatment packages provides the patient with a *mental health skill*. Therefore, none of the traditional programs provides the patient with a method for managing the action of the "thought-voices" (first referred to on page #8) which presently work against one's reasoned-self. Counter-Conditioning Therapy® allows the patient to be in charge of his mental functioning by counteracting the negative features of his chronic pattern. Consequently, the patient begins to mentally operate differently.

No present therapy takes into account the fact, when someone poisons himself with booze, drugs, or what-ever, he has created a condition of systemic depression merely through the act of ingesting that chemical. Nor do current traditional therapies pay clinical regard to treatment issues such as chronic depression, latent dissatisfaction accompanied by low-level anxiety. Instead, current substance-abuse programs place predominant attention upon the moral question of "sinning." Traditional programs ignore common knowledge--as distinct from theory--that the chemically-based cause of an acute abusing condition overlays an already existent long-term chronic depressive condition.

THE PROPOSITIONS TESTED

The Center's empirical data indicates that our patients consistently restrict their use of alcohol to manageable proportions, that they are able to use alcohol moderately without promiscuously lapsing into abuse. All realize for the first time, how their incipient depression feeds their abusing activity. Through their participation, the Center's patients discover that the clinical emphasis is not upon analyzing or figuring out the origins of their emotional upset, but is instead focused upon current painful behavior and what to do about it now.

Finally, the clinical impact and efficiency in design of the "Counter-Conditioning Therapy®" format would financially benefit institutions and industries by producing a higher success rate in substance-abuse programs than is currently available. Whenever a divergent methodology such as "Counter-Conditioning Therapy®" appears, the suspicions of the invested community abound. To compare the efficacy and practicality of the "Counter-Conditioning Therapy®" substance-abuse program with that of the medical and spirituality methodologies requires an in-depth study. Financial and institutional resources (cooperative efforts) are necessary for such a venture.

It must be emphasized that the Center has established a treatment design which is distinct and apart from the disease-model used by the traditional mental health field. The "Counter-Conditioning Therapy®" modality applies a format which is uniquely amoral as contrasted with the "morally correct" overtones attached to the spirituality-oriented, "people engineering" approach. Rather, "Counter-Conditioning Therapy®" places the treatment emphasis upon the role which a patient's non-volitional mental activity plays in fostering disruptive behavior.

ETIOLOGY OF METHOD

Over 30 years of clinical treatment experience in the Provinces of Saskatchewan and British Columbia and the State of California, have provided the developmental foundation, whereby, Norman A. Gillies formulated this unique psychotherapy. Counter-Conditioning Therapy® is a unified, non-volitional system psychotherapy designed to treat all categories of mental health cases. The substance-abuse program is but one of the Center's clinical areas, treating hundreds of alcohol-abusing patients since 1980. The authors have found that the clinical treatment areas described in this report are the same for abusers of cocaine and marijuana either singly or in

combination. Applying the same clinical procedures to those substance-abuse categories has produced equally positive results.

UNIQUE FEATURES IN COUNTER-CONDITIONING THERAPY®

The clinical "apparatus" or change agent is "Counter-Conditioning Therapy®." Here follow the seven key elements:

1st----The traditional clinical design of "understanding" the etiology of the patient's condition is not employed. Instead, the therapist applying "Counter-Conditioning Therapy®," follows a treatment design which is "skill-teaching" oriented.

2nd----The therapy process employs experiential data provided by the patient. The treatment goal is satisfied, only, when there is an "operational" (not an attitudinal) change in the patient's mental functioning.

3rd----Counter-Conditioning Therapy® engages the patient in a therapy task aimed at interrupting and disrupting certain negative items of thought. It is the emotional hold of these negative items of thought within the patient's pattern which habitually produces his emotional upset.

4th----All information provided by the patient is accepted by the therapist as truthfully given throughout the treatment process. Consequently, there is no attempt by the therapist to "fit" the patient's past experiences into the therapist's particular treatment theory.

5th----The Center's substance-abuse program introduces a mental health "skill" configuration to the field of mental health treatment. This new configuration alters the clinical emphasis away from that of medical-model psychotherapies; it is a structural change that transforms the clinical task of the therapist to one of imparting a skill.

6th----Because this is a skill-oriented treatment procedure, the clinical focus is upon the patient acquiring a personal mental health *ability*. The format follows standard, but precise, steps used in all activities of a skill nature; for instance, learning to play the violin or tennis. First, there is a "teacher," the C-CTherapy® therapist, who possesses the skill and is able to instruct the learner. Secondly, the steps of skill building require that the learner:

(a) decide to add an ability onto his already established behavior-base;

(b) discover for himself the mental character of his mental pattern, that is the patient's emotional functioning;

(c) concentrate on carrying out specific exercises assigned by the therapist;

(d) experience a degree of familiarity by the tentative use of his new-found "skill facility." This step is always practised under the guidance of the therapist;

(e) apply this newly acquired mental facility in his every-day surroundings.

7th----The uncluttered treatment design is uniquely fitted to the specific needs of an out-patient substance-abuse psychotherapy program.

SUBJECTS TREATED

An alcohol abuser is defined as anyone who regularly, and without premeditation, consumes more alcohol than his physiology can tolerate. Because they regularly "poison" themselves, the symptoms and behavior exhibited are:

(1) "a hung-over" state and diminished functioning and

(2) the patient's aberrant behavior is called, repeatedly, to the attention of the societal authorities, courts, physicians, etc.

Patients in the Center's program, who meet this definition, cover a complete spectrum of race, religion, gender, and socio-economic category. They range in age from 18 to 75, with the majority of patients grouped between 32 and 61 years of age. Additionally, the Center considers demographics irrelevant because the "Counter-Conditioning Therapy®" methodology is applicable to all human beings, no matter their circumstance.

CASE ILLUSTRATION

The following case example of chronic abusing is taken from four typical treatment sessions and illustrate what the C-CTherapy® therapist pays attention to.

First, let the patient introduce herself and her worry:

I'm really concerned about my drinking. I haven't told anybody because I keep thinking it's okay and everybody does it. I've been drinking everyday half a bottle of wine for four or five years now; only every once in a while, do I drink more. But, I'm really scared right now. I don't know if I'm scared enough to really stop. I'm scared to stop and I'm scared not to stop. I'm telling myself it's a lot more serious than I've thought in the past. I'm afraid that I'm killing myself.

Chronic depression as the basis for substance abusing:

The therapist's initial clinical task is to focus the patient's attention upon her emotional mentality. Our patient describes an accumulation of lifelong disappointments, a "list" of grievances which she discovers fuel her substance abusing behavior. The Center's findings concur with a commonly held observation, that substance abusers suffer from a constant state of low to medium level depression. "Woe is me." Here the patient notifies us of her depression:

"I shut down and I felt like I was six years old. The words in my head were saying: `You're naughty, a bad girl, you shouldn't want things.' For the rest of the afternoon I felt despair and was pre-occupied by my weight gain. I can't do anything right. Physically I shut down; mentally, it's like there's no place to go. That's when I drink."

Her comments illustrate the depressive themes: "Woe is me"; "nothing to look forward to"; "I can't." It is this emotionally produced activity which, on her own, she has been trying to eradicate via "self-medication."

What produces a substance abuser?

Like all substance abusers, our patient wants relief from her chronic mental upset. The common denominator in all human beings and especially substance abusers, is their drive to move from "feeling bad" to "feeling good." Our research, beginning in 1980 regarding this clinical matter, indicates that abusers come from mentally depressive, human-conditioning backgrounds. That is, they were reared by depressives who used the most available anaesthetic for the purpose of making their lives bearable; in this particular instance, alcohol is the anaesthetic.

Initially, substance abusing is the quickest way to reduce mental malaise. The inclination to anesthetize oneself, which leads to over-use, is perpetuated by a strong human behavior motivator, chronic depression. We refer here to low to medium range depression, ennui or boredom. (Repeated suicide attempts, break-downs, unexplained crying jags come under the heading of acute depressive-reaction and are therefore treated at the Center separately from the category being examined.)

We have found that the ordinary person who tends to abuse is bright, inquisitive, and routinely pre-occupied by a complaining activity. The abuser over-consumes to alleviate his negative emotional behavior -- ennui, boredom or dissatisfaction with life. Consumption items are not limited to chemical substances but may include food, gambling, and binges involving the unneeded or frivolous purchase of goods. One can readily appreciate that many people fit into the prerequisites of abusing behavior.

The patient hears her depression:

As the disappointments of life accumulate, the depressive reaction grows more intense. The "Counter-Conditioning Therapy®" clinician asks "what thought voices pop into your head"? I hear, she replies, "nothing to look forward to", "I can't", "I don't behave right". She is beginning to hear her pattern in action - the type of thinking which belongs to depression. Here are the words from her taped session:

"As long as I can remember, my emotions have run real high and then, bang, I close down again. I argue in my head. I want a guarantee from myself that I'm not going to do that routine again. But my head says, 'You've done this before, you know that you'll have three good weeks, and suddenly when you realize things are going well, then you'll screw up again.'"

As the patient verbalizes her thought voices, the therapist and reader can recognize the themes common to chronic depression: "You can only count on bad, you can't count on good." "I'm incurable and nothing changes." "Woe is me." The reader will appreciate the patient's need for relief from the chronic mental pain produced by these sorts of thought voices. The abuser customarily attempts to reduce his discomfort by taking an anesthetizing substance. Unfortunately, poisoning oneself has its negative down-side. "What goes up, has to come down"!

How did the patient become an abuser?

An inherent characteristic of being a human being is that children copy the behavior of their elders. In this substance-abuse case instance, the developing child inadvertently copied the parents' constantly verbalized dissatisfaction about "life in general." Therefore, the child, now our patient, grew up with a dissatisfied view of "life." Not only does the child copy a chronic state of dissatisfaction, but also copies the tactic for relief -- self-medication. If, for instance, the parent uses booze to anesthetize the bad feeling created by his or her constant state of dissatisfaction, it is possible - but not inevitable - that the child, as an adult, will use booze to suppress the constant state of agitation inadvertently copied from the parent. This clinical discovery supports the "passed from generation to generation" phenomenon, not because of "genes," but for normal human development reasons.

In the "Counter-Conditioning Therapy®" treatment process, the therapist asks the patient "What person or

persons, during your childhood, did you copy?" This question pinpoints the "human being derivation" of his emotional conditioning. As the patient becomes attuned to his non-volitional, emotional conditioning, he begins, over time, to recapture the language and messages of the older generation. In this same way the patient will eventually identify who he copied in the use of alcohol. Of course, then the patient makes the mental connection between depression, and, in this instance, "drinking." He is then able to appreciate that the ritual is a part of his acquired mental make-up rather than something that mysteriously occurred.

How the "derivation question" works:

In this case example, the patient identifies *what* she copied from her childhood, the depressive atmosphere.

"When I look at the pattern I can see that it goes way back in my life: When I've been excited about something, I've not been supported by the people around me. They never said, 'Don't feel good,' it was their actions more than words."

Then she identified *who* she copied.

"When I was in high school, my mom would get so depressed that a doctor would give her B-12 shots. I never ever talked about it. The interesting part is, I always thought that I did not do anything like my mother because I've always felt alienated from her."

The patient was surprised to discover that she *could* have copied such a thing. She had no idea that human beings acquire their mental conditioning merely by being around other human beings.

The "Counter-Conditioning Therapy®" clinician clarifies and emphasizes for the patient that the copying activity happens developmentally during childhood *without any deliberate mental directive.* The therapist reinforces this newly acquired discovery: "People copy each other." Then the therapist instructs the patient to listen for the presence of depressive thoughts. Eventually, inside her head, the patient hears the tone and theme of depressive thinking.

"I'm terrified if I'm not good, if I don't do what they say. "They" is the judgment that I hear in my head; the fear being, that I won't survive. The way to get safe is to obey them."

But she also hears thoughts of logic and reason commenting on her real situation.

"I heard my head say, 'Look at your finances, you don't really need to make more money.'"

In the above quote, our patient heard her volitional division declaring a reasonable assessment of her finances. Both quotes highlight the difference in treatment approach between that of the traditional, medical-model therapy modalities and that of "Counter-Conditioning Therapy®." C-CTherapy® divides functioning mentality into two major divisions. One is the non-volitional which as you have already read is emotive and reactive. And the other is the volitional which is based upon logic and reason. (For further discussion about the mental divisions, see "A Study of Three Short-Term Psychotherapy Cases Employing Counter-Conditioning Therapy®," Norman A. Gillies, 1990)

Next, our patient actually hears her adversarial thinking -- back and forth between the non-volitional, emotive demands and the "yes buts" of the volitional, logic and reason thoughts. But, the non-volitional declaration is the louder and stronger as our patient says:

"Yet what I hear inside my own head was, "oh yes I do need to make money so people will approve of me, will think I'm a good girl."

Our patient uncovers a personal insight. If she doesn't obey the depressive thought-voices, she won't feel like her usual self. She hears the contradiction between the command "get safe with money" and the fact that she isn't "unsafe." She knows the real information -- there is no actual danger. In her financial position she does not need to work in order to survive. Therein lies the puzzle: if volitional thinking (logic and reason) were the only operating mental feature then there would be no adversarial thinking. But that is not human mental functioning. As the patient discovered, "I am run by the illogical, non-volitional mental commands."

Patient begins to hear her non-volitional thinking:

Here is a sample of the non-volitional mental activity directing her in spite of any volitional (deliberate) thinking.

"You can tell me ten good things and one thing that isn't good and my head goes: 'See, there it is you're not doing it right.' All gets the same force of judgement in my own head. No matter what the negative is, it outweighs all the positive."

Even though the volitional system speaks logic and reason, the patient's habit is to pay attention to the emotional, illogical commentary - the non-volitional system. This is the puzzle: as she obeys the pattern she experiences pain even though the real information of logic and reason provide her with a profoundly different mental message.

From where does reinforcement of abusing originate?

Drinking is a common custom in which people participate. Ending the abusing behavior leaves the substance abuser (alcohol or drugs) in the position of not knowing what to do with the unstructured time available. The people with whom the abuser once associated, no longer hold the same appeal. No longer is there a common activity or experience to talk over with "buddies." Nor are there common "substance abuser" happenings to discuss.

What research alludes to as genetically-based behavior (a pre-disposition of the person to carry on with abusing despite its debilitating effects) is none other than habit-based ritualistic behavior. When any one of our patients quits "boozing," he doesn't know what to do with the time liberated by the absence of the ritual. Interruption of the abusing-based ritual produces an anxious, emotionally dissatisfied state. The low tolerance for anxiety - because it produces mental pain - causes the patient to take up "boozing" all over again. Our patient testifies to that experience:

"I quit drinking for two months on two occasions, when I was going through the allergy testing. One was two years ago and the other was three and one-half years ago. But I didn't deal with any of the emotional issues so I went right back."

In those moments when she operates outside of the depressive reaction, she doesn't feel quite right, she feels at "loose ends" and uncomfortably "out of sorts." She has illustrated the strength of the non-volitional system and its prevailing thoughts oriented around "feeling bad." The result is that when she doesn't obey the non-volitional, emotional habit to feel bad, she reacts with a high-level of anxiety. Many times, in order to quell the anxiety, the abuser is prone to return to the use of the familiar negative features of the ritual, poisoning oneself with "booze." To avoid that pitfall a substitute or replacement activity must be established. For that replacement activity to be

effective enough to reduce the anxiety created by the "I don't know what to do with myself," the activity must be meaningful.

The patient discovers her ritual:

As is usual with most abusing patients, our case had no initial sense of the ritual-like makeup of her drinking activity. The therapist assigns the patient the task of becoming acquainted with the characteristics of a ritual-like activity. At the next session the patient outlines some of her drinking routine.

"When I know that I don't want to drink very much I'll have vodka and orange juice because those are specific, measured amounts. When I drink wine, I tend to drink more. When things aren't going well with my job, I tend to drink more. I was getting really depressed about my job, and I found myself drinking at lunch. And then last year I decided that didn't sound good, that sounds like someone who has a drinking problem. So I stopped drinking at lunch. And I thought I'm `OK'. "

She continues to acquaint herself with the mechanics of her ritual. She describes the *behavioral* cues, which are an elaboration of her routine.

At night, I tend to drink more when I'm by myself, when I'm making dinner, and then with dinner. If I'm with someone and things are okay, I have one glass of wine or one beer and that's fine. It has to do with my stress level.

As the patient practises her assignment to hear the mechanics of her ritual, she feels more in control of her emotions. The assignment becomes appealing and she picks-up the subtle *mental cues* of her ritual. Increasingly, she becomes familiar with the non-volitional mental activity which activates her long-standing ritual. As you read her commentary, notice how the "yes-no" discussion is integral to the ritual.

"There seems to be more of a debate in my head of whether I will or not. Can I not do this tonight? I know that there is a discussion about whether it's going to take place or not. There's a lot that goes on before I pour the wine. I know that when I'm depressed I drink more."

Within the complexity of her mental cues she discovers another component - the need to reward herself.

"What surprised me was when I need love is when I drink, when I'm being depressed, when I feel mad at myself, when I feel like I've let somebody down. Those are things that I do when I'm by myself. On the days that I go home really up, when something good has happened, then I drink to celebrate."

And she discovered the need to recreate the gregarious "feeling good" times - the social ritual. Here again she speaks:

"Drinking is what you do when you're with people. I watched and sure enough when my sister and I were talking and having a good time, we had a beer and when I'm with people, one or two drinks. When I'm by myself, it's like, it's that fun-time that I think I'm keying into."

In this instance, the patient craves the *social* character of the ritual. She describes people gathering together for the purpose of like-activity, drinking; as if they belonged to an informal "Club".

The social, "Club-like" atmosphere of the ritual is significant to the abuser. He gains implied membership to the "Club" which gives him something to do, some place to go, someone to talk with and something to talk about. It

provides a milieu within which the abuser finds companionship and a heightened, alcohol-induced "comraderie." Precipitous "removal" of the ritual leaves the participant with both no "Club" membership, no companionship, but lots of unstructured free-time. He does not know what to do with himself which for most people creates a panicky state.

The clinician must not underestimate the strength and power of the non-volitional mental feature, i.e the patient's automatic mental admonishment to put faith into negative conclusions; for instance, "I can't do anything right" and "No one loves me" -- the feeder for depression. The inclination to hear mental negativity activates the abusing behavior. As our patient said, "it runs" her. Without the ritualized activity involving a substance, an abuser has no way of coping with the action of his or her low-level chronic depression. Without the support of his "Club" and the particular "anaesthesia," the patient is left in a state of social-mental limbo.

The "not knowing what to do with oneself," in itself, produces anxiety. If the pain of this reaction is too great the abuser will once again seek the support of his "Club" and its "ritual." In that setting, relief is assured. It is plain to the veteran clinician, that in addition to the chronic depression, the patient experiences a reaction to the removal of the ritualized behavior. For clinical treatment to be lasting, therefore, it must address both of these non-volitional mentally-based matters, not knowing what to do with oneself and the "Club" gatherings.

COUNTER-CONDITIONING THERAPY® TREATMENT APPROACH

Counter-Conditioning Therapy® meets all the clinical demands of such a treatment approach. The therapist directs the patient to practise outside of the therapy office. The patient, because he *cannot think*, experiences the mental workings of his long-ago acquired ritual. The authors have found that, in all instances, the patient is surprised that he *can* actually hear the mental contents producing the depressive activity. The patient is equally surprised that he can experience the mental workings of these components because, formerly, he thought some mysterious factor was causing him to be ill. He had operated from the position of "I have a sickness, I am not to blame."

But now, his newly-developed ability to hear his mental workings which cause his abusing behavior nullifies that illness mythology. The patient now possesses a data-base different from theory, his own experience. The contradiction between the non-volitional system, his old thought pattern, and the patient's implementation of contemporary information makes it difficult for him to remain victimized by the mythology.

SUMMARY

The matters outlined in this paper are germane to the treatment program offered by the Center regarding substance-abuse cases. In order to be successful, any clinical substance-abuse program must incorporate in its practise design the following three areas:

1. Chronic depression is based upon and is mobilized by inadvertent, copied behavior-items originating in childhood.

2. Substance abusing is the patient's creative attempt to deal with incipient chronic depression via his own "treatment" program.

3. Substance abusing is both socially and mentally ritualistic in nature. Both areas are disrupted when the patient ceases to participate in the social allure of the substance-abuse "Club." If a treatment program fails in its treatment

design to address the above clinical features, it will produce inconsistent results.

In addition to the research findings, all of the above material is supported by a clinical base of experience which covers a combined period of well over 50 years in the mental health field. The authors are reporting that as with this typical substance-abuse case treated at the Center, none of the Center's substance-abuse patients have returned to abusing any substance, neither to the substance initiating their need for treatment, nor to any other substance. Those who have returned to using, have not returned to abusing; and, more importantly, have not returned to the mental state which lies at the root of their abusing.

SUPPORTING DOCUMENTATION

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